



Please return completed form to the Utilization Management Department at (401)459-6023.

Please refer to Neighborhood's *Clinical Medical Policy* which is available on our Neighborhood web site, www.nhpri.org for more detailed information about this benefit, authorization requirements, and coverage criteria.

MEMBER INFORMATION		
Member's Name:	Member's ID #:	Member's DOB:
PROVIDER INFORMATION		
Provider's Name:	Provider ID # (Please call Provider Services for your ID #):	Date of Request:
Date of Service:	Previous Auth #:	Place of Service (City/Town)/Facility:
Provider's Phone #:	Provider's Fax #:	Provider's Contact Name:
CLINICAL INFORMATION		
Diagnosis & Diagnosis Code:		Procedure & Procedure Code:
<input type="checkbox"/> Progressive Lenses	Rationale _____	
<input type="checkbox"/> Polycarb Lenses for Adults	Rationale _____	
<input type="checkbox"/> Polychromic Lenses	Rationale _____	
<input type="checkbox"/> Topograhay	Rationale _____	
<input type="checkbox"/> Fundus Photography	Rationale _____	
<input type="checkbox"/> Other Request	Rationale _____	
SERVICES REQUESTED INSTRUCTIONS: Please select requested service and check YES or NO.		
<input type="checkbox"/> Replacement lenses age 21 years old and over. (Eyeglass frames are covered only every 2 years.)	Change in refraction of at least 0.5 diopter (lens spherical equivalent)	Yes <input type="checkbox"/> No <input type="checkbox"/>
<input type="checkbox"/> Plastic Frames (Please select any that apply)	1.) Skin reaction/allergy is documented and attributable to metal frames.	Yes <input type="checkbox"/> No <input type="checkbox"/>
	2.) Member is a child.	Yes <input type="checkbox"/> No <input type="checkbox"/>
<input type="checkbox"/> High Index Lenses	Prescription is (-10) or above and lens does not fit into frame.	Yes <input type="checkbox"/> No <input type="checkbox"/>
<input type="checkbox"/> Punctal Plugs (Please respond to both 1 & 2)	1) History of using artificial tears without success	Yes <input type="checkbox"/> No <input type="checkbox"/>
	2) Trial use of collagen plugs which dissolve in 7-12 days with success, i.e. symptom relief	Yes <input type="checkbox"/> No <input type="checkbox"/>
<input type="checkbox"/> Contact Lenses (Please select any that apply)	1) High myopia (> -6.00)	Yes <input type="checkbox"/> No <input type="checkbox"/>
	2) Keratoconus that cannot be corrected with glasses.	Yes <input type="checkbox"/> No <input type="checkbox"/>
	3) Anisometropia with diopter difference > 3. (Difference in the power of required lens power of the two eyes of greater than a spherical equivalent of 3 diopters.)	Yes <input type="checkbox"/> No <input type="checkbox"/>
	4) Aphakic Contact lens for aphakia	Yes <input type="checkbox"/> No <input type="checkbox"/>
NOTE: THIS FORM MUST BE SIGNED BY A PHYSICIAN		
Signature of Treating Physician:		Date:
NEIGHBORHOOD DECISION		
Authorization #:	Dates of Service	Services Approved:
UM Initials:	Notification Date:	<input type="checkbox"/> Not Approved - Letter to Follow